Agency for Healthcare Research and Quality
Advancing Excellence in Health Care

NATIONAL GUIDELINE CLEARINGHOUSE

General

Guideline Title

Patient-clinician communication: American Society of Clinical Oncology consensus guideline.

Bibliographic Source(s)

Gilligan T, Coyle N, Frankel RM, Berry DL, Bohlke K, Epstein RM, Finlay E, Jackson VA, Lathan CS, Loprinzi CL, Nguyen LH, Seigel C, Baile WF. Patient-clinician communication: American Society of Clinical Oncology consensus guideline. J Clin Oncol. 2017 Nov 1;35(31):3618-32. [69 references] PubMed

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

= Poor = Fair = Good = Very Good = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group
YES	Methodologist Involvement

	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
	Search Strategy
	Study Selection
	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
	Grading the Quality or Strength of Evidence
	Benefits and Harms of Recommendations
	Evidence Summary Supporting Recommendations
	Rating the Strength of Recommendations
	Specific and Unambiguous Articulation of Recommendations
	External Review
	Updating

Recommendations

Major Recommendations

Definitions for the rating of evidence (High, Intermediate, Low, Insufficient); types of recommendations (Evidence based, Formal consensus, Informal consensus, No recommendation); and strength of recommendations (Strong, Moderate, Weak) are provided at the end of the "Major Recommendations" field.

Note from the National Guideline Clearinghouse (NGC): Recommendations are accompanied by suggested strategies for implementation in the original guideline document.

Clinical Question 1

What core communication skills and tasks apply at every visit, across the cancer continuum?

Recommendation 1.1: Before each conversation, clinicians should review the patient's medical information, establish goals for the conversation, and anticipate the needs and responses of the patient and family (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 1.2: At the beginning of conversations with patients, clinicians should explore the patient's understanding of their disease and collaboratively set an agenda with the patient after inquiring what the patient and family wish to address and explaining what the clinician wishes to address (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 1.3: During patient visits, clinicians should engage in behaviors that actively foster

trust, confidence in the clinician, and collaboration (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 1.4: Clinicians should provide information that is timely and oriented to the patient's concerns and preferences for information. After providing information, clinicians should check for patient understanding and document important discussions in the medical record (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 1.5: When patients display emotion through verbal or nonverbal behavior, clinicians should respond empathically (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 2

What communication skills and tasks may clinicians use when discussing goals of care and prognosis?

Recommendation 2.1: Clinicians should provide diagnostic and prognostic information that is tailored to the patient's needs and that provides hope and reassurance without misleading the patient (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 2.2: Clinicians should reassess a patient's goals, priorities, and desire for information whenever a significant change in the patient's care is being considered (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 2.3: Clinicians should provide information in simple and direct terms (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 2.4: When providing bad news, clinicians should take additional steps to address the needs and responses of patients (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 3

What communication skills and tasks may clinicians use when discussing treatment options (including best supportive care) and clinical trials?

Recommendation 3.1: Before discussing specific treatment options with the patient, clinicians should clarify the goals of treatment (cure v prolongation of survival v improved quality of life) so that the patient understands likely outcomes and can relate the goals of treatment to their goals of care (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 3.2: When reviewing treatment options with patients, clinicians should provide information about the potential benefits and burdens of any treatment (proportionality) and check the patient's understanding of these benefits and burdens (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 3.3: Clinicians should discuss treatment options in a way that preserves patient hope, promotes autonomy, and facilitates understanding (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 3.4: Clinicians should make patients aware of all treatment options, including clinical trials and a sole focus on palliative care. When appropriate, clinicians should discuss the option of initiating palliative care simultaneously with other treatment modalities. If clinical trials are available, clinicians should start treatment discussions with standard treatments available off trial and then move to a discussion of applicable clinical trials if the patient is interested (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 4

What communication skills and tasks may clinicians use when discussing end-of-life care?

Recommendation 4.1: Clinicians should use an organized framework to guide the bidirectional communication about end-of-life care with patients and families (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 4.2: Clinicians should initiate conversations about patients' end-of-life preferences early in the course of incurable illness and readdress this topic periodically based on clinical events or patient preferences (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 4.3: Clinicians should explore how a patient's culture, religion, or spiritual belief system affects their end-of-life decision making or care preferences (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 4.4: Clinicians should recognize and respond empathically to grief and loss among patients, families, and themselves. Clinicians should refer patients and families to psychosocial team members (e.g., social workers, counselors, psychologists, psychiatrists, and clergy) when appropriate (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 4.5: Clinicians should identify and suggest local resources to provide robust support to patients, families, and loved ones transitioning to end-of-life care (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 5

What communication skills and tasks may clinicians use to facilitate family involvement in care?

Recommendation 5.1: Clinicians should suggest family and/or caregiver involvement in discussions (with patient consent) early in the course of the illness for support and discussion about goals of care (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 5.2: Determine if a formal family meeting in a hospital or outpatient setting is indicated at important junctures in care. When possible, ensure that patients, their designated surrogates, and desired medical professionals are present (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 6

What communication skills and tasks may clinicians use when there are barriers to communication such as language differences and/or low literacy or numeracy?

Recommendation 6.1: For families who do not share a common language with the clinician, use a medical interpreter rather than a family interpreter (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 6.2: For patients with low health literacy, focus on the most important points, use plain language, and check frequently for understanding (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 6.3: For patients with low health numeracy, use pictographs or other visual aids, when available, and describe absolute risk rather than relative risk (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 7

Should clinicians discuss cost of care with patients?

Recommendation 7: Clinicians should explore whether cost of care is a concern for patients with cancer (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 8

What communication skills and tasks may clinicians use to help meet the needs of underserved

populations, racial and ethnic minority patients, and other patients from groups that have experienced discrimination historically?

Recommendation 8.1: Enter clinical encounters with a sense of curiosity, aware that any patient and family, regardless of their background, may have beliefs, experiences, understandings, and expectations that are different from the clinician's (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 8.2: Avoid assumptions about sexual orientation and gender identity and use nonjudgmental language when discussing sexuality and sexual behavior (Type of recommendation: formal consensus; Strength of recommendation: strong).

Recommendation 8.3: Remain aware that members of underserved or marginalized populations have an increased likelihood of having had negative past health care experiences, including feeling disrespected, alienated, or unsafe (Type of recommendation: formal consensus; Strength of recommendation: strong).

Clinical Question 9

What are the most effective ways for clinicians to acquire communication skills?

Recommendation 9.1: Communication skills training should be based on sound educational principles and include and emphasize skills practice and experiential learning using role-play scenarios, direct observation of patient encounters, and other validated techniques (Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong).

Recommendation 9.2: For communication skills training to be most effective, it should foster practitioner self-awareness and situational awareness related to emotions, attitudes, and underlying beliefs that may affect communication as well as awareness of implicit biases that may affect decision making (Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong).

Recommendation 9.3: Facilitators of communication skills training should have sufficient training and experience to effectively model and teach the desired communication skills and facilitate experiential learning exercises (Type of recommendation: evidence based; Quality of evidence: intermediate; Strength of recommendation: strong).

Definitions

Guide for Rating Quality of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
Formal consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. Therefore, the Expert Panel used a formal consensus process to reach this recommendation, which is considered the best current guidance for practice. The Expert Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak"). The results of the formal consensus process are summarized in the guideline and reported in the Data Supplement (see the "Availability of Companion Documents" field).
Informal Consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Expert Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Expert Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Expert Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Cancer

Guideline Category

Counseling

Management

Clinical Specialty

Internal Medicine

Oncology

Radiation Oncology

Surgery

Intended Users

Advanced Practice Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To provide guidance to oncology clinicians on how to use effective communication to optimize the patient-clinician relationship, patient and clinician well-being, and family well-being

Target Population

Adults with cancer

Interventions and Practices Considered

1. At every visit
    - Review of patient's medical information and establishing goals for conversation
    - Engaging in behaviors that foster trust and confidence in the clinician
    - Timely advice oriented to the patient's preferences
    - Empathetic behaviors and responses
2. Discussion of goals of care and prognosis
    - Provision of diagnostic and prognostic information in simple and direct terms
    - Reassessment of patient's goals, priorities, and desire for information
    - Addressing the needs and responses of the patient when giving bad news
3. Discussion of treatment options and clinical trials
    - Clarification of goals of treatment
    - Provision of information on benefits and burdens of treatment
4. Discussion of end-of-life care
    - Bidirectional communication (patients and families) using an organized framework
    - Initiation of conversations about end-of-life preferences, including cultural concerns
    - Referral to psychosocial team members and local support resources
5. Use of communication to facilitate family involvement
6. Use of medical interpreters, plain language for patients with low health literacy, and pictographs or other visual aids for patients with low health numeracy

7. Discussion of cost of care
8. Use of communications skills to meet needs of specific populations
    - Awareness of different beliefs, experiences, and expectations
    - Use of nonjudgmental language when discussing sexuality and sexual behavior
9. Acquisition of communication skills
    - Skills training based on educational principles
    - Fostering practitioner self-awareness and situational awareness
    - Training of facilitators of communication skills

Major Outcomes Considered

- Changes in health care provider communication skills
- Patient satisfaction

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

The systematic review of the literature involved searches of PubMed and the Cochrane Library for the period from January 1, 2006 through October 1, 2016. Searches were limited to guidelines, systematic reviews, meta-analyses, and randomized controlled trials (RCTs). Articles were selected for inclusion if they focused on in-person communication between clinicians and adults with cancer. Articles were excluded if they were (1) meeting abstracts not subsequently published in peer-reviewed journals; (2) editorials, commentaries, letters, news articles, case reports, narrative reviews; (3) published in a non-English language; (4) focused on cancer prevention, risk assessment, or screening; (5) focused on decision aids or specific communication tools; or (6) focused on specific symptoms, such as pain. For the question on clinician training in communication skills, systematic reviews and RCTs were only included if they were published after the 2013 Cochrane review of communication skills training.

Number of Source Documents

A total of 47 publications met the eligibility criteria of the systematic review. Three of the publications precede the search window of the systematic review and were identified by panel members. Much of the evidence consisted of systematic reviews of observational data, consensus guidelines, and randomized trials, which varied substantially in their populations, interventions, and outcomes of interest. A list of identified publications is provided in Data Supplement 1 (see the "Availability of Companion Documents" field).

See Data Supplement 5 for a Quality of Reporting of Meta-analyses (QUOROM) Diagram showing exclusions and inclusions of publications identified for the systematic review.

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Guide for Rating Quality of Evidence

Rating for Strength of Evidence	Definition
High	High confidence that the available evidence reflects the true magnitude and direction of the net effect (i.e., balance of benefits versus harms) and that further research is very unlikely to change either the magnitude or direction of this net effect.
Intermediate	Moderate confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research is unlikely to alter the direction of the net effect; however, it might alter the magnitude of the net effect.
Low	Low confidence that the available evidence reflects the true magnitude and direction of the net effect. Further research may change either the magnitude and/or direction this net effect.
Insufficient	Evidence is insufficient to discern the true magnitude and direction of the net effect. Further research may better inform the topic. The use of the consensus opinion of experts is reasonable to inform outcomes related to the topic.

Guide for Rating of Potential for Bias

Rating of Potential for Bias	Definitions for Rating Potential for Risk of Bias in Randomized Controlled Trials
Low risk	No major features in the study that risk biased results, and none of the limitations are thought to decrease the validity of the conclusions. The study avoids problems such as failure to apply true randomization, selection of a population unrepresentative of the target patients, high dropout rates, and no intention-to-treat analysis; and key study features are described clearly (including the population, setting, interventions, comparison groups, measurement of outcomes, and reasons for dropouts).
Intermediate	The study is susceptible to some bias, but flaws are not sufficient to invalidate the results. Enough of the items introduce some uncertainty about the validity of the conclusions. The study does not meet all the criteria required for a rating of good quality, but no flaw is likely to cause major bias. The study may be missing information, making it difficult to assess limitations and potential problems.
High risk	There are significant flaws that imply biases of various types that may invalidate the results. Several of the items introduce serious uncertainty about the validity of the conclusions. The study has serious errors in design, analysis, or reporting; large amounts of missing information; or discrepancies in reporting.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Data Extraction

Literature search results were reviewed and deemed appropriate for full text review by one American Society of Clinical Oncology (ASCO) staff reviewer in consultation with the Expert Panel Co-Chairs. Data were extracted by one staff reviewer and subsequently checked for accuracy through an audit of the data by another ASCO staff member. Disagreements were resolved through discussion and consultation with the Co-Chairs if necessary. Evidence tables are provided in Data Supplement 1.

Methods Used to Formulate the Recommendations

Expert Consensus (Delphi)

Description of Methods Used to Formulate the Recommendations

Guideline Development Process

The American Society of Clinical Oncology (ASCO) convened a multidisciplinary Expert Panel to consider the evidence and formulate the recommendations. The Expert Panel met in person and via teleconference and corresponded through e-mail. Based on the consideration of the evidence, clinical experience, and a formal consensus process, the authors were asked to contribute to the development of the guideline, provide critical review, and finalize the guideline recommendations. Members of the Expert Panel were responsible for reviewing and approving the penultimate version of the guideline.

Because of the limited evidence available for most of the clinical questions, recommendations were developed using the ASCO modified Delphi formal consensus methodology. This process involved the drafting of recommendations by a subgroup of the Expert Panel using clinical expertise and the available evidence. The Expert Panel met in person to review the recommendations. The Expert Panel was then supplemented by additional experts, who were recruited to rate their agreement with the recommendations. The entire membership of experts is referred to as the Consensus Panel. Each recommendation had to be agreed to by at least 75% of Consensus Panel respondents to be accepted.

The recommendations in the original guideline document are accompanied by strategies for implementation that were developed by the Expert Panel. These strategies were not voted on by the Consensus Panel, but the Consensus Panel was invited to comment on them. The Expert Panel also indicated the strength of each recommendation. For the evidence-based recommendations, the strength of the recommendation was driven by quality of the evidence. For the consensus recommendations, the strength of the recommendation was based on the opinion of the Expert Panel.

Rating Scheme for the Strength of the Recommendations

Guide for Types of Recommendations

Type of Recommendation	Definition
Evidence based	There was sufficient evidence from published studies to inform a recommendation to guide clinical practice.
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Informal Consensus	The available evidence was deemed insufficient to inform a recommendation to guide clinical practice. The recommendation is considered the best current guidance for practice, based on informal consensus of the Expert Panel. The Expert Panel agreed that a formal consensus process was not necessary for reasons described in the literature review and discussion. The Expert Panel may choose to provide a rating for the strength of the recommendation (i.e., "strong," "moderate," or "weak").
No recommendation	There is insufficient evidence, confidence, or agreement to provide a recommendation to guide clinical practice at this time. The Expert Panel deemed the available evidence as insufficient and concluded it was unlikely that a formal consensus process would achieve the level of agreement needed for a recommendation.

Guide for Strength of Recommendations

Rating for Strength of Recommendation	Definition
Strong	There is high confidence that the recommendation reflects best practice. This is based on (1) strong evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with no or minor exceptions; (3) minor or no concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a strong recommendation.
Moderate	There is moderate confidence that the recommendation reflects best practice. This is based on (1) good evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, with minor and/or few exceptions; (3) minor and/or few concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other compelling considerations (discussed in the guideline's literature review and analyses) may also warrant a moderate recommendation.
Weak	There is some confidence that the recommendation offers the best current guidance for practice. This is based on (1) limited evidence for a true net effect (e.g., benefits exceed harms); (2) consistent results, but with important exceptions; (3) concerns about study quality; and/or (4) the extent of Expert Panelists' agreement. Other considerations (discussed in the guideline's literature review and analyses) may also warrant a weak recommendation.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The guideline was circulated for external review and submitted to *Journal of Clinical Oncology* for editorial review and consideration for publication. All American Society of Clinical Oncology (ASCO) guidelines are ultimately reviewed and approved by the Expert Panel and the ASCO Clinical Practice Guideline Committee before publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

A 2013 meta-analysis suggested that communication training improved some clinician communication skills, such as empathy (six studies, high-quality evidence) and using open questions (five studies, moderate-quality evidence). Subsequent randomized controlled trials (RCTs) evaluated a range of different training programs and outcomes, but each reported some benefits of clinician training in communication skills. The duration of the training programs ranged from 7 to 40 hours, and five of the six trials noted that they included opportunities for role-play and/or practice of skills.

Potential Harms

In a 2013 meta-analysis, communication skills training was not associated with improved patient outcomes, but few studies assessed these outcomes. The review noted that it remains uncertain whether training benefits are sustained over time and which types of training are best.

Qualifying Statements

Qualifying Statements

- The Clinical Practice Guidelines and other guidance published herein are provided by the American Society of Clinical Oncology, Inc. (ASCO) to assist providers in clinical decision making. The information herein should not be relied upon as being complete or accurate, nor should it be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. With the rapid development of scientific knowledge, new evidence may emerge between the time information is developed and when it is published or read. The information is not continually updated and may not reflect the most recent evidence. The information addresses only the topics specifically identified therein and is not applicable to other interventions, diseases, or stages of diseases. This information does not mandate any particular course of medical care. Further, the information is not intended to substitute for the independent professional judgment of the treating provider, as the information does not account for individual variation among patients. Recommendations reflect high, moderate, or low confidence that the recommendation reflects the net effect of a given course of action. The use of words like "must," "must not," "should," and "should not" indicates that a course of action is recommended or not recommended for either most or many patients, but there is latitude for the treating physician to select other courses of action in individual cases. In all cases, the selected course of action should be considered by the treating provider in the context of treating the individual patient. Use of the information is voluntary. ASCO provides this information on an "as is" basis and makes no warranty, express or implied, regarding the information. ASCO specifically disclaims any warranties of merchantability or fitness for a particular use or purpose. ASCO assumes no responsibility for any injury or damage to persons or property arising out of or related to any use of this information, or for any errors or omissions.
- See the "Health Disparities," "Multiple Chronic Conditions" and "Discussion and Future Directions" sections in the original guideline document for additional qualifying information.

Implementation of the Guideline

Description of Implementation Strategy

Guideline Implementation

American Society of Clinical Oncology (ASCO) guidelines are developed for implementation across health settings. Barriers to implementation include the need to increase awareness of the guideline recommendations among front-line practitioners and survivors of cancer and caregivers and also to

provide adequate services in the face of limited resources. The guideline Bottom Line Box was designed to facilitate implementation of recommendations. This guideline will be distributed widely through the ASCO Practice Guideline Implementation Network. ASCO guidelines are posted on the ASCO Web site and most often published in *Journal of Clinical Oncology* and *Journal of Oncology Practice*. ASCO believes that cancer clinical trials are vital to inform medical decisions and improve cancer care, and that all patients should have the opportunity to participate.

For additional information on the ASCO implementation strategy, please see the ASCO Web site .

Implementation Tools

Patient Resources

Quick Reference Guides/Physician Guides

Slide Presentation

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

End of Life Care

Getting Better

Living with Illness

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Gilligan T, Coyle N, Frankel RM, Berry DL, Bohlke K, Epstein RM, Finlay E, Jackson VA, Lathan CS, Loprinzi CL, Nguyen LH, Seigel C, Baile WF. Patient-clinician communication: American Society of Clinical Oncology consensus guideline. J Clin Oncol. 2017 Nov 1;35(31):3618-32. [69 references] PubMed

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Nov 1

Guideline Developer(s)

American Society of Clinical Oncology - Medical Specialty Society

Source(s) of Funding

American Society of Clinical Oncology (ASCO)

Guideline Committee

Patient-Clinician Communication Guideline Expert Panel

Composition of Group That Authored the Guideline

Expert Panel Members: Timothy Gilligan, MD (*Co-Chair*), Taussig Cancer Institute and the Center for Excellence in Healthcare Communication, Cleveland Clinic, Cleveland, OH; Walter F. Baile, MD (*Co-Chair*), The University of Texas MD Anderson Cancer Center, Houston, TX; Nessa Coyle, NP, PhD (*Steering Committee*), Memorial Sloan Kettering Cancer Center, New York, NY; Richard M. Frankel, PhD (*Steering Committee*), Regenstrief Institute, Indiana University School of Medicine, Indianapolis, IN; Donna L. Berry, RN, PhD (*Practice Guideline Implementation Network [PGIN] representative*), Dana-Farber Cancer Institute, Harvard Medical School, Boston, MA; Ronald M. Epstein, MD, University of Rochester School of Medicine, Rochester, NY; Esme Finlay, MD, University of New Mexico School of Medicine, Albuquerque, NM; Vicki A. Jackson, MD, MPH, Massachusetts General Hospital, Harvard Medical School, Boston, MA; Christopher S. Lathan, MD, MS, MPH, Dana-Farber Cancer Institute, Harvard Medical School, Boston, MA; Charles L. Loprinzi, MD, Division of Medical Oncology, Mayo Clinic, Rochester, MN; Lynne H. Nguyen, MPH, Department of Health Disparities Research, The University of Texas MD Anderson Cancer Center, Houston, TX; Carole Seigel, Patient/Advocacy Representative, Brookline, MA; Kari Bohlke, ScD, American Society of Clinical Oncology (ASCO) Staff

Financial Disclosures/Conflicts of Interest

Guideline and Conflicts of Interest

The Expert Panel was assembled in accordance with American Society of Clinical Oncology's (ASCO's) Conflict of Interest Policy Implementation for Clinical Practice Guidelines (Policy, found at https://www.asco.org/about-asco/legal/conflict-interest). All members of the Expert Panel completed ASCO's disclosure form, which requires disclosure of financial and other interests, including relationships with commercial entities that are reasonably likely to experience direct regulatory or commercial impact as a result of promulgation of the guideline. Categories for disclosure include employment; leadership; stock or other ownership; honoraria, consulting or advisory role; speaker's bureau; research funding; patents, royalties, other intellectual property; expert testimony; travel, accommodations, expenses; and other relationships. In accordance with the Policy, the majority of the members of the Expert Panel did not disclose any relationships constituting a conflict under the Policy.

Authors' Disclosures of Potential Conflicts of Interest

The following represents disclosure information provided by authors of the guideline. All relationships are considered compensated. Relationships are self-held unless noted. I = Immediate Family Member, Inst = My Institution. Relationships may not relate to the subject matter of this manuscript. For more

information about ASCO's conflict of interest policy, please refer to www.asco.org/rwc or ascopubs.org/jco/site/ifc.

Timothy Gilligan: Travel, Accommodations, Expenses: WellPoint

Nessa Coyle: No relationship to disclose

Richard M. Frankel: No relationship to disclose

Donna L. Berry: Research Funding: Medocity (Inst)

Kari Bohlke: No relationship to disclose

Ronald M. Epstein: No relationship to disclose

Esme Finlay: Stock or Other Ownership: Merck

Vicki A. Jackson: No relationship to disclose

Christopher S. Lathan: Honoraria: PER; Consulting or Advisory Role: Gerson Lehrman Group, Eli Lilly, Bristol-Myers Squibb; Research Funding: CVS Health

Charles L. Loprinzi: Consulting or Advisory Role: Lpath, Janssen Pharmaceuticals (Inst), Mundipharma; Research Funding: Janssen Pharmaceuticals (Inst), Bristol-Myers Squibb (Inst)

Lynne H. Nguyen: No relationship to disclose

Carole Seigel: No relationship to disclose

Walter F. Baile: Honoraria: Empathetics, MDVIP, Eli Lilly

Guideline Status

This is the current release of the guideline.

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Journal of Clinical Oncology Web site.

Availability of Companion Documents

The following are available:

- Patient-clinician communication: American Society of Clinical Oncology consensus guideline. Methodology supplement. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2017. 17 p. Available from the Journal of Clinical Oncology Web site.
- Patient-clinician communication: American Society of Clinical Oncology consensus guideline. Data supplement. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2017. 20 p. Available from the Journal of Clinical Oncology Web site.
- Patient-clinician communication: American Society of Clinical Oncology consensus guideline. Summary of recommendations table. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2017. 13 p. Available from the American Society of Clinical Oncology (ASCO) Web site.
- Patient-clinician communication: American Society of Clinical Oncology consensus guideline. Slide set. Alexandria (VA): American Society of Clinical Oncology; 2017. 43 p. Available in PDF and PowerPoint from the ASCO Web site.

Patient Resources

The following is available:

Navigating challenges: talking with your cancer care team. Video. [internet]. Alexandria (VA): American Society of Clinical Oncology (ASCO); 2017 Sep 5. Available from the Cancer.Net Web site .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC summary was completed by ECRI Institute on January 31, 2018. The guideline developer agreed to not review the content.

This NEATS assessment was completed by ECRI Institute on January 8, 2018. The information was verified by the guideline developer on January 9, 2018.

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